Vermont Mental Health Performance Indicator Project
Weekly Report
August 13, 1999

Reimbursement Mechanism and Practice Patterns in Washington State

The relationship between program performance and reimbursement mechanism has been an important issue in mental health services research and program evaluation since the beginning of the managed care revolution in American health care. The pages that follow shed light on this relationship by comparing the level of access to care before and after implementation of modified reimbursement systems in three regions of Washington State. Each of the pages that follow provides a brief description of the reimbursement system (and its underlying values) and a graph that compares the number of people in each of three service utilization categories. In each graph, the bar to the left in each pair represents the pre-managed care utilization rate and the bar to the right represents the managed care utilization rate. (Because the original was in color, the distinction is lost in this copy.) The analysis was conducted by Nancy Callahan and her colleagues as part of an HCFA independent assessment of the Washington State 1915b Medicaid Waiver that was conducted by the federal Health Care Financing Administration (HCFA).

As you will see, there were substantial differences among regions in the impact of the change from fee-for-service reimbursement. When Region #1 changed to a flat rate per client reimbursement system, it experienced a substantial increase in the number of people served (from 1.9% to 3.6% of the residents of the region), but almost all of the increase was in the low utilization category. Region #2, which changed to a five-tier system based on medical necessity with large differences in reimbursement among tiers, experienced a slight increase in overall penetration (from 1.2% to 1.3%) but had moderate increases in the number of people in the highest and the lowest service categories. Finally, Region #3, which changed to a two-tier system with the lowest tier reimbursed on the basis of total Medicaid enrollment and the higher tier requiring pre-authorization, experienced a slight decrease in overall utilization (from 2.4% to 2.3%. Region #3 also experienced a slight decrease in the number of people in the lowest service category and a slight increase in the number of people in the highest service category.

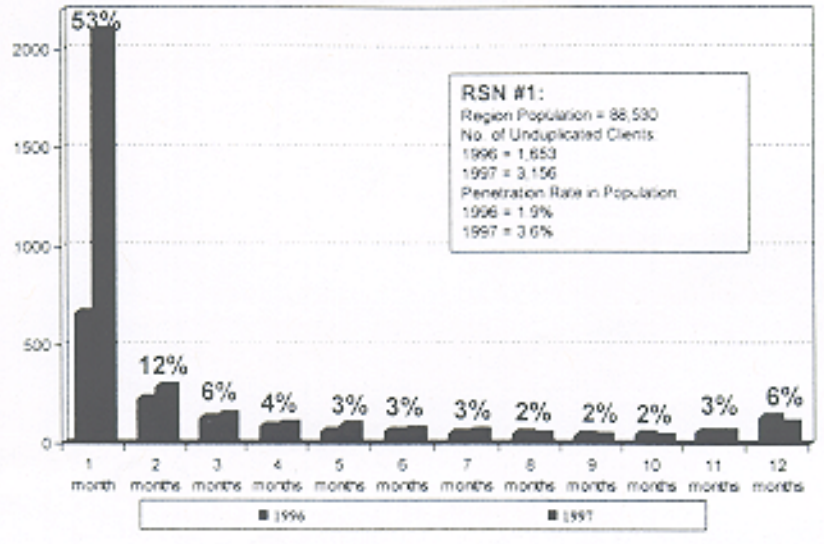
We are looking forward to sharing the results of our comparison of practice patterns that were observed under our old CRT fee-for-service reimbursement system with the practice patterns that will emerge under our new three-tiered CRT case rate reimbursement system. We will welcome your comments on the results of the Washington analysis and your suggestions for comparing practice patterns in Vermont. Please send your comments and suggestions to jpandiani@ddmhs.state.vt.us or call 802-241-2638.

Capitated Outpatient Managed Care System - RSN 1 Authorization System

- **Value**: all clients have equal access to service. Providers have some incentive to see all clients.
- **Authorization System**: Same dollar amount paid to providers for each client seen regardless of severity of condition or number of services delivered. Provider's annual allocation based on total number of clients seen in a year (estimated by previous year's utilization).

15

RSN #1: 1-12 graph



16

Capitated Outpatient Managed Care System - RSN 2 Authorization System

- **Value**: Different financial reimbursement for different levels of client needs based on medical necessity

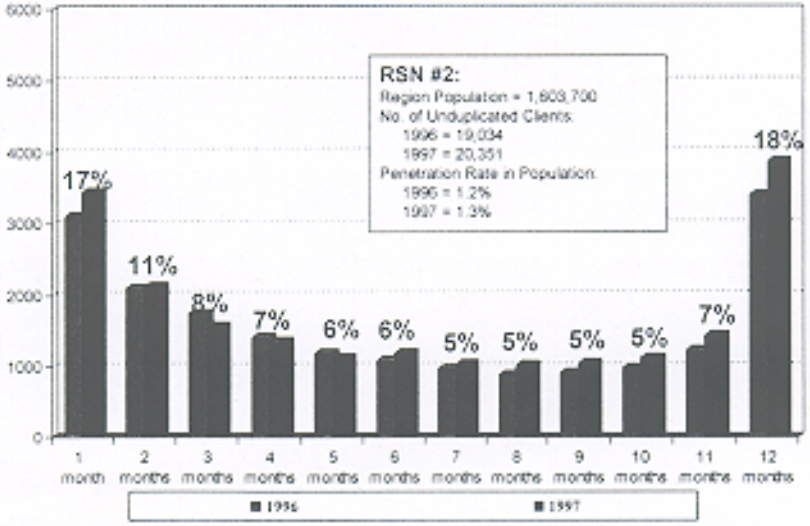
- **Authorization System**: 5 Tier Levels

Tier Levels	Annual Allocation
I. Brief Intervention	$280
II. Aftercare	$561
(Pre-authorization required for Levels III - V)	
III. Maintenance	$2,468
IV. Rehabilitation	$2,468
V. Exceptional Care	$7,854

Each Tier Level has an expected performance level (i.e., number of visits each month throughout the year). Dollars are taken back if service delivery is lower than mandated by the Tier Level.

18

RSN #2: 1-12 graph



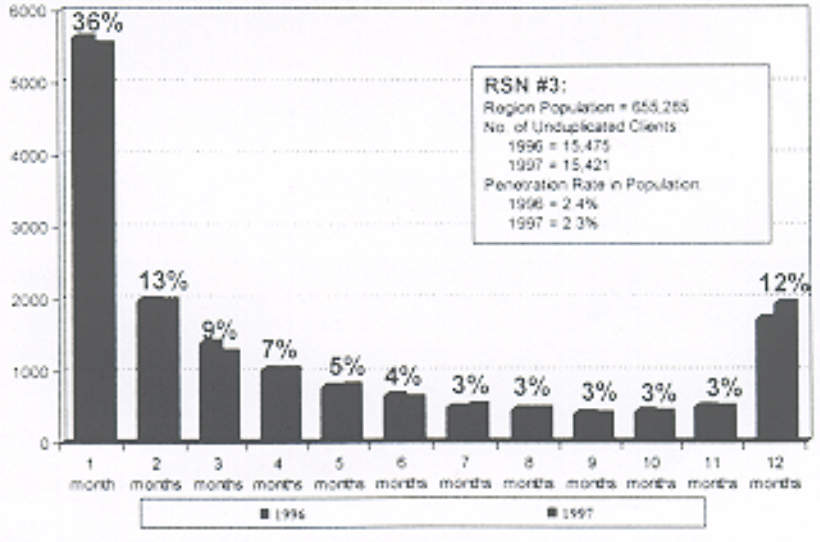
19

Capitated Outpatient Managed Care System - RSN 3 Authorization System

- **Value**: All clients should have easy access to services. Services for clients with complex problems are paid at a higher rate.
- **Authorization System**:
  - **Level 1**: Regional providers are paid an amount based on the number of Medicaid beneficiaries in the region and historical utilization.
  - **Level 2**: (Pre-authorization from RSN required) $650 per month for a negotiated number of months (ranging from 3 months to 2 years).

21

RSN #3: 1-12 graph



22

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